



DWC 15th Annual Educational Conference

AMA Guides and Substantial Evidence

Presenters

Colleen Casey
Robert Rassp

Los Angeles Sheraton February 28-29, 2008
Oakland Marriot March 3-4, 2008

**AMA Guides & Substantial Evidence
DWC Conference – 2008**

by
**Colleen S. Casey
Robert Rassp**

DISCLAIMER: The following material and any opinions contained herein are solely those of the author and are not the positions of the Department of Industrial Relations, the WCAB or any other entity or individual. The materials are intended to be a reference tool only and are not meant to be relied upon as legal advice.

Part I

The top 10 Mistakes in Doctor's Reports (and how to fix them):

Most doctors went to medical school to fix patients, rather than to write reports about them. Every day they perform medical miracles. This is why they went to medical school. This is what they do best.

No wonder it's tough for them to sit down and methodically read a 613 page book, like the AMA Guides and try to compartmentalize, explain and quantify their findings. This is **not** what they do best.

Often, physicians read only those few pages of the Guides that apply to their specialty. They have no clue what's in the rest of the book. Even in their own specialty, as you will see as we go through the following examples, they will read through a Table until they get to what might look like the right impairment rating. They write it down, close the book and smile, thinking this rating stuff isn't all that hard after all.

The problem is, more often than not, some doctors stop reading too soon. To fully comply with the new rating standards, which focus on **objective** data, rather than subjective complaints, physicians must ask certain critical questions of injured workers (IWs), take additional measurements with specified tools and consider ramifications on other body parts that were never considered before. Set forth below are excerpts from medical reports that illustrate the ten most common errors doctors make in this regard and how these reports should be supplemented in order to constitute substantial evidence.

Note: The report excerpts are real; the names are aliases, courtesy of Herman Melville.

1. **Use and Misuse of Clinical Judgment.**

Doctor Ahab writes: "In my **best clinical judgment**, this spinal impairment would rate at 25% Whole Person Impairment(WPI), rather than rating of the *AMA Guides* which would be 8%."

One of the most common dilemmas doctors encounter is when to deviate from the strictures of the *AMA Guides* and to rate the injured worker (IW) based solely on their own "best clinical judgment." Under the old system, doctors did this on a regular basis, which often led to widely inconsistent ratings for similar types of injuries, something the reform legislation had hoped to fix. **Objectivity and uniformity of ratings** and reproducibility of measurements was a guiding force behind the adoption of the *AMA Guides*.

There are times when physicians will be called upon to use their own clinical judgment, but, in general, this will occur only when a rating has not already been scheduled or addressed by the *Guides*. The support for this can be found on Page 1-4 of 2005 PDRS and page 11 of *AMA Guides*, which state that "if an impairment based on an **objective medical condition is not addressed** by the *AMA Guides*, physicians should use clinical judgment, comparing measurable impairment resulting from the **unlisted** objective medical condition to measurable impairment resulting from similar objective medical conditions, with similar impairment of function in performing activities of daily living." (Emphasis added.) Even when "clinical judgment" is used, the rating determination must still be based on **objective standards**.

In Dr. Ahab's case, since the *Guides* have already scheduled the rating for this spinal impairment, the Dr. Ahab must follow the specified chart for that impairment, rather than relying on his own clinical judgment as to what rating he thinks would best fit this injured worker (IW).

2. **The Doctor must follow *Escobedo/Gatten* on all issues.**

Doctor Bildad writes: "I can state with **some medical possibility**, that the IW's pain is considerably more than you'd normally find for this type of injury, therefore I'd tack a 3% WPI add-on here."

There is a very specific standard that physicians are required to meet in order for their opinions to constitute "substantial evidence." As set forth in the *Gatten* case, cited below, the three magic words the doctors must use to meet this standard are "**reasonable medical probability**." It is extremely important that the doctor use those specific three words when making a medical determination. A variation of these words such as "some medical possibility" or "it's more probable than not" or "in all medical likelihood," will not meet this standard.

Since Dr. Bildad used an incorrect standard, “some medical possibility” for his Whole Person Impairment (WPI) rating, his report **cannot** constitute substantial evidence.

In the case of *E.L. Yeager Constr’n v. WCAB (Gatten)*, (2006), 71 CCC 1687, the 4th DCA set the bar as to what constitutes substantial evidence to prove apportionment to non-industrial factors. They held, “Although the doctor does not state in his report that the apportionment is based on reasonable medical probability, he does do so in the deposition. This constitutes a sufficient basis for the apportionment.”

Gatten merely affirmed this “reasonable medical probability” standard, which was set forth by the WCAB in *Escobedo v. Marshall*, (2005) 70 CCC 604 (en banc) in order for a medical report to constitute substantial evidence. The WCAB defined the following issues as a roadmap for practitioners:

- (1) Causation of disability;
- (2) Standards for physicians & WCJs to determine apportionment percentages;
- (3) Applicant’s burden of proof as establishing that some percentage (%) of permanent disability (PD) was caused by industrial factors & defendant’s burden of proof as establishing the % of PD caused by non-industrial factors;
- (4) Non-industrial factors, which may include pathology, asymptomatic prior conditions, retroactive prophylactic work restrictions;
- (5) What a medical report needs to include in order to constitute substantial evidence.

Doctors don’t always understand how to apply the *Escobedo* analysis. In medical school, doctors spent a minimal amount of time studying causation of disease processes. Usually, factors of causation weren’t deemed significant, unless removal of that factor would cure the patient. Medical students more often focused on treatment options, than what caused the problem in the first place. So if the issue is causation, it might be helpful to research causation factors to give doctors a head start on this issue. Medical research websites include:

www.mayoclinic.com
www.webmd.com

The most important point to remember here, is that this “how & why” explanation standard of *Escobedo* and *Gatten* applies to all workers’ compensation issues, not just apportionment. And if the doctor has not provided an explanation for his conclusion, the record must be developed through supplemental report or deposition in order to comply with this standard.

3. **AMA Guides can be subject to interpretation – A doctor's rationale is an essential component of substantial evidence.**

Doctor Elijah writes, "Mr. Jones' surgical repair was successful. Although he has residual pain, and his ADLs are somewhat affected, I would place him in Class 1 at 1% WPI."

Just like a poem can be interpreted in several different ways, so can the language of the AMA Guides. In addition, punctuation is often missing, which can lead to multiple interpretations of the same data. One example of this, is in the chart for rating hernias, **Table 6-9** at page 136. This table sets forth the criteria for rating hernias. However, the table is missing some commas. The table groups the criteria into three different classes of hernias, each with a different range of WPI as follows:

Class 1 - 0-9% WPI

Class 2 – 10-19% WPI

Class 3 – 20-30% WPI

There are 3 criteria for each class.

- a. Palpable defect
- b. Slight protrusion
- c. Level of discomfort affecting Activities of Daily Living (ADLs)

For the first 2 classes, the formula is a + b or c. Because of the missing punctuation, that formula is subject to 2 different interpretations:

1st way: (a + b) or c

2nd way: (a + b) or (a + c)

Some physicians follow the 1st approach. They find that in order to qualify for a Class 2 hernia rating 10-19% WPI, you need "a + b" (a palpable defect + a persistent protrusion) **OR** you need **only** a "c" (frequent discomfort, precluding heavy lifting, but not hampering some activities of daily living).

Other physicians follow the 2nd interpretation and would require (a + b) or (a + c) to qualify for Class 1 (0-9%) or Class 2 (10-19%). Under this 2nd interpretation, the level of WPI rating would depend on the definition of "palpable defect." A selection of Class 1 or 0% WPI for a repaired hernia is not uncommon under this scenario, even when the IW still has considerable pain due to this condition.

It will be up to the trier of fact to determine which of the 2 interpretations is correct. Dr. Elijah only selected a WPI number from the chart. He did not address whether the injured worker had a palpable defect or slight protrusion. In addition, he did not state whether he considered those criteria in selecting that WPI number. Therefore, it will be impossible for the WCJ to determine whether the doctor has followed the selection criteria appropriately. On that basis, Dr. Elijah's report cannot be considered substantial evidence.

4. Doctors should designate the AMA Table used for Rating:

Doctor Ishmael writes, "The difference in Ms. Smith's thigh circumference is 1.9 cm and therefore would equal 2% WPI."

It is important for the doctor to designate the table, chart and page number from which they are selecting the Whole Person Impairment% (WPI%) so that the trier of fact is able to confirm that the doctor has interpreted the AMA Guides accurately.

Some doctors confuse **WPI%**, which is the rating for the **whole body**, with a Lower Extremity% (**LE**) rating or an Upper Extremity% (**UE**) rating, which is a rating for only **part** of the body.

A LE% must be multiplied by 40% to equal a WPI%.

An UE% must be multiplied by 60% to equal a WPI%.

The AMA Guides have provided conversion "Cheat Sheets" as follows:

Table 16-3 page 439 – Conversion chart for Upper Extremity% to WPI%

Table 17-3 page 527 – Conversion chart for Lower Extremity% to WPI%

Some tables, like **Table 17-5** at page 529 provide the WPI %, but other tables just give the UE% or LE%, and the doctors must do the WPI% calculation themselves. So it's easy to see why people might get confused, and forget to convert an UE% or a LE% to WPI%.

In addition, still other tables give both ratings. The first number is the WPI% and next to the WPI%, the table provides the UE% or LE % in brackets.

Still **other** tables, like **Table 17-6** at page 530 give the correct LE%, but next to it, they have the **INCORRECT** WPI%. (There are over 300 clerical errors in the AMA Guides.) In the last column of **Table 17-6**, the Guides state for Leg Muscle Atrophy:

Impairment Degree	WPI% (LE%)	
Mild (1-1.9cm)	1-2	(3-8)
Moderate (2-2.9cm)	3-4	(8-13)

It should read:

Impairment Degree	WPI% (LE%)	
Mild (1-1.9cm)	1- <u>3</u>	(3-8)
Moderate (2-2.9cm)	3- <u>5</u>	(8-13)

If the doctor has not specified the Table used for the selection criteria, there is no way to confirm whether he or she has selected an incorrect WPI% from **Table 17-6** or the correct LE%.

In the case of Doctor Ishmael above, he has indicated that the difference in circumference is 1.9cm which would equal 8% LE impairment per **Table 17-6**, but the WPI% for that would equal 3% ($8\% \times 40\% = 3.2\%$). It would not equal 2% which is incorrectly indicated in **Table 17-6** and which Dr. Ishmael copied and incorrectly indicated in his report. Also, since he did not designate which table (and page number) he used, the trier of fact would have a very difficult time tracking down these items to determine whether the doctor's rating was correct.

5. **Doctor must include all Measurements for a CTS rating.**

Doctor Moby writes, "Finally, the carpal tunnel condition translates to 5% upper extremity impairment for each wrist. I felt this qualifies for impairment because of the documented slowing of median nerve conduction on electrodiagnostic testing."

Doctor Moby's conclusion that there is a ratable impairment here is correct, because of the positive findings from the EMG. However, that is just one of the criteria necessary in order to rate a Carpal Tunnel Syndrome (CTS) condition. He also needs to perform motor deficit and sensory deficit testing. He needs to then specify what those measurements are in his report. Next, he must go through the selection process from the AMA Guides as set forth below, before he can arrive at an accurate rating of the injured worker.

There are 3 categories of CTS ratings as set forth on page 495. CTS is to be rated and not considered Maximum Medical Improvement (MMI) until after optimum recovery which = 1 year from DOI or date of surgery. (Surgery is not necessary in order to rate CTS, even though the Guides seem to indicate otherwise.)

1. Abnormal EMG + Abnormal sensory & motor deficits – This would indicate Median Nerve Damage. (A 3% pain add-on is permitted.)
2. Abnormal EMG + Normal sensory & motor deficits = 5% UE, (3% WPI) Some doctors have incorrectly been told that the maximum WPI allowed for a CTS is 3% WPI for each wrist, for a total of 6% WPI. There is no maximum WPI rating for CTS under the AMA Guides. (No pain add on is allowed for this category.)
3. Normal EMG + Normal sensory & motor deficits = 0% WPI

The Guides do not address the situation where an IW has a Normal EMG + Abnormal sensory & motor deficits. An argument could be made that WPI rating should be allowed under these circumstances. However, the doctor would have to provide a bulletproof rationale for this, because the primary “objective” data of impairment (EMG) is missing.

Many doctors fail to perform the sensory and motor deficits tests because they do not realize they exist. They do not realize that they can rate the Median Nerve Damage, for CTS cases, so they still use grip loss, which is barred on page 508 (with exceptions on page 507 & 508). Grip loss is thought to be less accurate than other types of measurements. The rationale for this is based on the injured worker (IW) experiencing significant levels of pain in the upper extremities. It is thought that the IW’s pain would prohibit him or her from applying maximum effort during the grip strength test. However, the Guides do provide certain exceptions to this general rule.

The following steps must be followed to accurately rate CTS (which is essentially median nerve deficit.) First, the doctor would review **Table 16-10** and determine the level of sensory deficit, such as a Grade 4, which would be a 25% loss of sensory deficit. Next, the doctor would review **Table 16-11** and determine the level of motor deficit, such as a Grade 4, which would be a 25% loss of motor deficit. If the doctor provides the Grade level, but not the % loss, then the rater will use the highest value for that grade. For this example, using the above measurements the procedure would be as follows:

(1) Test the Sensory Deficit and select a Grade for impairment-**Table 16-10** (page 482)
Example = Doctor selects Grade 4 = 25% Sensory Deficit (highest %)

(2) Test the Motor Deficit and select a Grade for Impairment-**Table 16-11** (page 484)
Example = Doctor selects Grade 4 = 25% Motor Deficit (highest %)

(3) Determine Maximum Impairment from **Table 16-15** (page 492)
Example = The line for CTS = Median Nerve (below midforearm)

Motor Deficit =	10% UE
Sensory Deficit =	39% UE

(4) Crunch the numbers based on the above example

Motor loss = 10% x 25% = 3% UE

Sensory loss = 39% x 25% = 10% UE

Use combined values chart to combine 10 + 3 = 13% UE

Then to convert to WPI, multiply by 13% (CTS%) x 60% (UE) = 8 WPI

CTS EXAMPLE #2: Dr. Melville correctly rates bilateral CTS at 17% WPI in 1st report. An independent physician/rater Dr. Loomings critiques with, “If there is ratable impairment, for carpal tunnel syndrome it cannot exceed 6% WPI.” To which Dr. Melville responds, “What the guides actually state is after a carpal tunnel release procedure, an impairment rating will not exceed 6%.” The statements of both doctors are incorrect. There is no maximum WPI for CTS under the AMA Guides.

Attorneys should request a supplemental report from the physician if:

- A physician has not reviewed an EMG
- A physician has not performed appropriate testing for sensory or motor deficit
- A physician has selected 6% WPI because he was told the Guides state that is the maximum for bilateral CTS.

6. **Make sure instructions are followed if ROM is used.**

Doctor Orca writes,

<u>Lumbar Range of Motion (ROM)</u>	<u>Observed</u>	<u>Normal</u>
Flexion	60	60
Extension	60	60

Doctors must use **objective measurements, tests AND tools** as instructed by the Guides. Doctors in the past simply watched the patient’s movements and “observed” Range of Motion (ROM). They did not use any **objective** tool of measurement to evaluate range of motion, except their eyes. This is the case with Dr. Orca in the above example. The Guides now prohibit “eyeballing” ROM. The Guides state on page 400, “...an inclinometer is the preferred device for obtaining accurate, reproducible measurements in a simple, practical, and inexpensive way.” In any event, under the Guides, some form of accurate measurement device, aside from the physician’s eyes, must be used for ROM testing.

Measuring Range of Motion (ROM) for spinal injuries is very complicated, but detailed instructions are provided on pages 402 to 403 of the Guides. The most common mistake made by doctors is that they take the average of three readings that they perform as the measurement to determine the impairment rating. Although the instructions indicate that doctors must average three readings, this is for reliability purposes only. If all three measurements do not fall within the larger of 5 degrees or 10% of the average, then the results must be disregarded as unreliable. (See #6 on page 403.) However, once the measurements are deemed to be credible and reliable, the instructions then state that the maximum motion is the one the doctor should select to determine the impairment rating. (See #7 on page 403.)

Also, many doctors forget to ask the patient to warm up prior to ROM testing which is required for a valid measurement. These warm up exercises are set forth in the last paragraph of page 399.

7. There are 13 ways for the Doctor to rate LE injuries:

EXAMPLE: Ms. Jonah is a school teacher. While trying to separate two children in a fight, one of the boys falls into the side of her knee and injures it. Her doctor diagnoses the injury as a torn lateral and medial meniscus and an ACL tear. He performs a meniscectomy to repair the damage. Xrays show 2mm of cartilage interval after the surgery. She continues to have considerable patellofemoral pain, pain under her knee cap. She now uses a cane to walk to work, but does not use it at home or in the classroom.

Doctor Pequod writes, "Following Table 17-33 (at page 546), I determine that Ms. Jonah's industrial injury would rate out at 1% WPI based on her partial meniscectomy."

The physician should have followed the checklist of measurement methods provided in **Table 17-1** to rate Ms. Jonah's LE injury all 13 ways if necessary:

Gait Derangement	(Table 17-5, page 529)	15% WPI
Muscle Atrophy	(Table 17-6, page 530)	1% WPI
Arthritis Degenerative Joint Disease (DJD)	(Table 17-31, page 544)	8% WPI
Diagnosis Based Estimate (DBE)	(Table 17-33, page 546)	7% WPI

Next the doctor should have reviewed **Table 17-2** to see if more than 1 measurement method should have been used in the combined rating. Generally, only Arthritis/Degenerative Joint Disease (DJD) & Diagnosis Based Estimate (DBE) can be combined. However, you can also combine the same methods if there are injuries in more than one location. In this case, the doctor should have combined all DBE ratings, the meniscus tear on the lateral and the meniscus tear on the medial side of the left knee, and the ACL tear.

Meniscus tear on the lateral AND	
Medial side of left knee*	= 4% WPI
ACL tear**=	= <u>3% WPI</u>
Total DBE rating	= 7% WPI

*Doctor Pequod stopped reading **Table 17-33** when he got to the line “Meniscectomy, medial *or* lateral and pulled the 1% WPI for the Partial Meniscectomy.” But he actually performed a medial *and* lateral meniscectomy which is rated on the *next line* at 4% rather than 1%. He should have kept reading. He stopped too soon.

Note: There is not a scheduled rating for an ACL tear, but perhaps a DBE rating for the ACL tear may be analogized to a "Ligament Laxity," **Table 17-33, page 546. The anterior draw sign is evidence of ACL instability or damage and based upon that diagnosis alone, the case is ratable under ligament laxity even though the ACL replacement or repair surgery may remove the laxity.

The Doctor also did NOT notice the 2nd footnote on **Table 17-31**, which reads:

“In an individual with a history of direct trauma, a complaint of patellofemoral pain and crepitation on physical exam but without joint space narrowing on X-rays, a 2 % whole person or 5 % LE impairment is given.”

Next the doctor would combine the DBE & DJD ratings as follows:

DBE ratings (2)	7% WPI
DJD rating (arthritis)	8% WPI
Table 17-31-2nd footnote	<u>2% WPI</u>
Total WPI	= 17%

The doctor would then have the following choice of WPI ratings:

Gait Derangement - 15% WPI

Muscle atrophy - 1% WPI

Combined DJD & DBE - 17% WPI

DEU policy states that the gait derangement measurement already includes pain, and won't allow add-on pain 3%.

The 3% pain add on could be added to Ms. Jonah's WPI for the combined DJD & DBE rating, if the doctor adequately justifies the add-on, which is explained in section 10.

8. Doctor must follow the Guides & not make it up as she goes.

In this case, the Injured worker (IW) takes NSAIDs to control pain for industrial orthopedic condition, which resulted in a compensable consequence of an ulcer.

Doctor Rachel writes, "Based on the patient's current symptoms and the severity of his gastrointestinal bleed, the patient best fits in class II, which is 10% to 24% WPI. In this class, patients have symptoms and signs of upper digestive tract disease... Patients in class II require appropriate dietary restrictions and drugs for control of symptoms, signs or nutritional deficiency. Mr. Herman does require daily Zantac to control his symptoms. He avoids spicy foods and caffeinated beverages. He does not have weight loss, which is typical for class II, below desirable weight. Instead, he has gained 13 pounds, and for that reason, I feel that the patient has 22% WPI, because of the absence of any loss of weight."

According to **Table 6-3**, at page 121, which deals with the upper digestive tract, the patient must have **three** criteria to be placed in Class 2 (10% - 24% WPI). In this case, Mr. Herman is missing criteria **#3**, "weight loss below desirable weight." Doctor Rachel merely glosses over that missing criteria and "feels" the patient should be rated under Class 2 anyway. The doctor's feelings really can not constitute substantial evidence on this issue. The fact that the patient is missing one of the key criteria to be placed in Class 2 is significant. It is clear from these facts that this patient would fall in Class 1 for a WPI between 0% - 9%, instead and Doctor Rachel's report on this issue would not constitute substantial evidence.

9. Incorrectly rating side affects from Meds.

Doctor Stubb wrote, "I have assigned this patient a 1%WPI based on the side affects from his meds."

In order to constitute substantial evidence on this issue, Doctor Stubb should state the specific medication this patient is taking and how the medication is adversely affecting the patient's ADLs. Dr. Stubb should also state where in the Guides he finds authority for his rating.

There are 3 types of ratings for effects of medications:

a. The first type can be found on page 20 of the Guides, where medication may cause a total remission of the IW's condition. In those circumstances, the doctor may assign an impairment of between 1 to 3%... sort of a token prize for getting better.

b. The second type can be found at page 600 of the AMA Guides, which states, "Medication may impact the individual's signs, symptoms, and ability to function. The physician may choose to increase the impairment estimate by a small percentage (1% to 3%) to account for effects of treatment." This appears to be the type of medication impact that Dr. Stubb is referencing.

c. The third type is when medication taken for the industrial injury CAUSES all sorts of ratable industrial conditions, such as liver disease, ulcers, GERD and kidney disease. In these situations, the underlying condition should be rated separately from the secondary compensable injury.

For example, often people with an industrial heart disease are put on the medication Coumadin. Coumadin may cause damaging side affects to an individual's blood system. If appropriate, an IW's blood condition from the use of Coumodin may be analogized to a blood disorder, under Chapter 9 of the AMA Guides, which would then be added to the impairment rating of the IW's overall WPI.

10. Incorrectly using the 1-3% Pain Add On:

Doctor Tashtego wrote, "Therefore, he would have 8% WPI for the right knee, but none for the left. However, the patient does have some discomfort with the left knee, and in my opinion a 3% impairment for pain on the left side would be considered reasonable."

The 1-3% pain "add on" may *only* be added to a body part that already has a ratable impairment. In this case, the only body part with a ratable impairment is the right knee. Therefore, that's the only body part eligible for a pain add-on. The doctor's 3% pain add on to the left knee with no impairment would not be valid.

Applicant's attorney might possibly take the deposition of Doctor Tashtego in this case, explain these rules, and then ask, "Didn't you really mean to add the 3% to the right knee?" IF the doctor says yes, the Defense attorney will then ask the doctor if that is true, then where in the IW's medical chart does he find the support for that. That is, where does the doctor note in any of his records or reports that the IW told him that his right LE is giving him more pain than would normally be expected with an injury like this.

In order to add on up to 3% for pain you need the following:

- Pain more severe than would be normal for this injury
- Pain is impacting Activities of Daily Living (ADL) severely
- Applicant is credible with regard to his/her claim of pain

Part II -Developing the Record -With the AMA Guides

NOTE: The following materials have been excerpted, modified and reprinted with permission from the third edition of Robert G. Rassp, *The Lawyers' Guide to the AMA Guides and California Workers' Compensation* (to be published January 2008). All rights reserved. Copyright © 2007 by Matthew Bender & Co., Inc., a member of the LexisNexis Group.

I. Compliance with the AMA Guides – LC 4660(b)(1)

A. Checklists from 8 CCR 10606 & Section 2.6 of Guides at page 21-22

Physician's Minimum "Face to Face" Time – 8 CCR §§49.2-49.8

Useful Checklists for each body part -AMA Guides:

Chapter 13 - Central Nervous System – Table 13-25 page 352

Chapter 15 - Spine Evaluation Summary – Table 15-20 – Page 429

Chapter 16 - Evaluating UE Impairments – Figure 16-1a&b – page 436

Chapter 17 – LE impairment evaluation record – Figure 17-10 – Page 561

(also **cross usage chart** - Table 17-2 on page 562 is also helpful)

B. **Was a computer used?** Many physicians are using a computer program to calculate impairment ratings for upper extremity cases. A word of caution is in order for the use of those computer generated impairment ratings for upper extremities. The commercial computer programs in use today do not account for variations in population averages for upper extremity range of motion testing. So a computer would indicate that the athlete or piano player would not have any impairment. Also, computer programs cannot interpolate an impairment rating that falls between two points on a pie chart – the computer would default to a higher or lower “listed” rating and the rating would not be accurate.

C. Are all affected body parts addressed? If not, then should A be sent to a specialist? Additional diagnostic tests?

II. How to Develop the Record with deficient Medical Reports:

A. Chapter 17 – Lower Extremities – Specific Injury Left Knee

1. A 35 year old probation officer had a specific injury to his right knee, which resulted in a diagnosis of torn lateral meniscus. The doctor performed a chondroplasty of the lateral femoral and tibial condyles. Doctor used Table 17-33 on page 546 of the Guides to assign a 1% WPI rating. He used one of the 13 possible methods for rating IW's impairment and didn't consider the footnote in Table 17-31. A consideration of these other methods could result in a WPI as high as 10%.

Table 17-31 footnote: “In an individual with a history of direct trauma, a complaint of patellofemoral pain and crepitation on physical exam but without joint space narrowing on X-rays, a 2 % whole person or 5 % LE impairment is given.”

TABLE 17-2 REFERENCES

<u>TABLE(S)</u>	<u>EVALUATION METHOD</u>
17-4	LIMB LENGTH DISCREPANCY
17-5	GAIT DERANGEMENT
17-6	MUSCLE ATROPHY
17-7, 8	MUSCLE STRENGTH
17-9 TO 17-30	ROM, ANKYLOSIS
17-31	ARTHRITIS/DEGENERATIVE JOINT DISEASE
17-32	AMPUTATION
17-33, 34 AND 35	DIAGNOSIS BASED ESTIMATES
17-36	SKIN LOSS
17-37	PERIPHERAL NERVE INJURY
13-15*	CRPS
17-38	VASCULAR

*SEE SECTION 13.8 OF AMA GUIDES FOR INSTRUCTIONS ON CRPS

SEE TABLE 17-2 FOR A CHECKLIST OF WHAT METHODS CAN BE COMBINED WITH EACH OTHER. ALL METHODS CAN BE COMBINED WITH THEMSELVES.

B. Chapter 17 – Lower Extremities - Avulsion Fracture - Left Foot

On July 25, 2005, the applicant, a 24 year old office assistant, twisted her foot and ankle feeling sharp pain to the lateral side of her left foot. X-rays revealed an avulsion fracture of the 5th metatarsal bone. She was placed in an equalizer boot with use of crutches for four weeks. On November 22, 2005 she began feeling increased pain along the medial band of her plantar fascia on her left foot that was secondary to the injury resulting in plantar fasciitis. She was prescribed orthotics.

At the MMI examination on April 10, 2006 she was tolerating the orthotics well and had “less pain on the bottom of her left arch. There was minimal swelling of the left foot.” Range of motion to all digits of the left foot and muscle strength were normal. “Her calf muscles have almost equal circumference.” (RASSP NOTE: Table 17-31 says 1 cm of atrophy of the calf is ratable but doctor does not give actual measurements of calfs).

After declaring that the Applicant has reached MMI, the physician states as follows:

“According to the AMA Guides, the Applicant has no permanent impairment to perform all activities of daily living. She has no weakness of her muscles and no atrophy of muscles or limitations of any pedal or ankle joint ranges of motion.”

“...[I]n the future should she develop increased pain to the left foot, she should be treated on an industrial basis. Conservative therapy could include immobilization, physical therapy, anti-inflammatory medications and steroid injections. She may be also eligible for new functional foot orthoses if necessary. If she is not responsive to conservative therapy, surgery may become necessary to reduce the pain in her left foot.”

For a correct analysis of this case, see Table 17-33 “Metatarsal Fractures,” “Metatarsalgia;” Table 17-31 for x-ray evidence of cartilage interval loss for metatarsal joints; Table 17-6 for any calf atrophy; Plantar fasciitis is not listed in the AMA Guides but Chapter 1 allows impairment rating by analogy – e.g. see Tables 17-25 to 17-29 for plantar ankylosis and especially the example 17-11 on page 542-543. The physician should not have rated the Applicant’s plantar fasciitis as a 0% WPI because she needs an assistive device, i.e. the orthotics. He should have rated her without use of the orthotics as mentioned above and may have added up to 3% WPI for effects of the injuries on standing, walking and stair climbing under Table 1-2 on page 4 – ADL functioning. This could have been combined with the other factors mentioned in this paragraph. Alternatively, the use of an ankle foot orthosis (an AFO brace) rates 15% WPI under Table 7-5(d) and the physician could have rated this case entirely on that basis alone.

ASSISTIVE DEVICES

“Chapter 2 of the AMA *Guides* indicates that the examiner in most cases should evaluate a patient without the use of assistive devices, if possible. For example, a patient who is using a cane probably can be evaluated without its use while a patient

with a lens implant will have to be evaluated for vision using the lens *in situ*. Under the 1997 PDRS for example, hearing loss was tested with the use of hearing aids based upon the assumption that a person does not lose any of his or her ability to compete in the open labor market if hearing aids are provided on an industrial basis. However, the authors of the *Guides* indicate that assistive devices are artificial and are not useful in determining a person's whole person impairment.

The authors of the *Guides* indicate that the physician can evaluate a person without the use of assistive devices and compare the results to any rating the person has with the use of the device. Also, physicians should evaluate any separate impairment that is caused by the actual use of assistive devices. For example, if a person has to rely on the use of a cane to walk and that person as a result of putting weight on the hand-arm-shoulder of the side he or she uses the cane and develops impairment to the hand-arm-shoulder, then that additional impairment is combined with the lower extremity rating that led to the medically required use of the cane."

"0% PD CASES: The message here is that if a medical report rates 0% PD, the physician's conclusions must be suspect if the underlying injury resulted in an objective injury, such as in this example, a fractured foot.

Here, the Applicant sustained a fractured fifth metatarsal. After conservative treatment (an immobilizer boot for 6 weeks), the applicant developed plantar fasciitis on the same foot from the altered gait. The physician prescribed a left foot orthotic which he stated is required for as long as the Applicant "has trouble" with the foot. Eight months after the injury the Applicant is P&S with a 0% PD. She signs a Stipulation for 0% PD and the WCJ rejects it and awards a "nominal PD of 2% pursuant to Labor Code Section 5802." Defendants file a Petition for Recon which is granted and WCJ is reversed. The WCAB panel ordered 0% PD because the doctor failed to indicate that permanent disability "was likely to occur in the future" which is a condition for an award of nominal PD under that section.

The problem was that the WCJ should have developed the record. The physician's report was not substantial evidence in the first place. Table 17-33 has a scheduled DBE rating for a metatarsal fracture and one with metatarsalgia. Table 17-31 allows for a rating that is combinable with the DBE rating if there is a reduction in the cartilage interval within the metatarsal joint from the fracture. The physician failed to take an x-ray to see what the cartilage interval was when the bone healed. He also failed to test for any ankylosis which is on Table 17-? If the toe was fixed (although he said the toe had normal range of motion in his report). Finally, plantar fasciitis is not rated in the AMA Guides. Since the Applicant needed an orthotic, you determine an impairment rating without assistive devices. Without the orthotic, the Applicant would have difficulty with prolonged walking, standing, stair climbing, etc. which are ADLs. The physician failed to take that into account and could have awarded additional impairment rating for that by analogy to an ankle impairment that is listed and/or up to 3% for the effects of the plantar fasciitis on the Applicant's ADL functioning. So there should have been separate ratings for the fractured metatarsal and for the plantar fasciitis. As stated above, Table 17-5(d) could

have been utilized by the physician to apply to the entire left foot since a rating for use of an ankle foot orthosis rates 15% WPI and this rating could have been used by analogy since plantar fasciitis is not in the Guides.

C. Chapter 16 - Upper Extremities - Distal Clavicle Resection Arthroplasty

Under the AMA *Guides*, can an impairment rating be based upon muscle strength loss? For example, an AME was confronted with a case involving a patient who has carpal tunnel syndrome at the right wrist, right thumb de Quervain's tenosynovitis and right elbow medial epicondylitis and the AME wanted to use grip strength as a ratable impairment.

He opined in his report that the reason he wanted to use grip strength loss was because of the three diagnoses that occurred in this case which involve three areas that immediately affect the patient's midforearm which is primarily responsible for grip and pinch strength and the physician stated that he felt the loss of strength was permanent and the best method of rating the overall impairment because there was no loss of motion nor ratable neurological deficits, except, arguably, grade 4 motor deficits for the median and ulnar nerves.

In this case, the physician had stated his rationale for his use of the muscle strength loss method of rating impairment and he followed the instructions in the AMA *Guides* while using the muscle strength loss rating method and his conclusions may constitute substantial evidence. Bear in mind, however, in no less than four places the authors of the AMA *Guides* caution physicians not to use grip loss as a primary or even secondary method of evaluating impairments especially if there are other methods that more accurately reflect the person's impairment.

In fact, there are Tables throughout Chapters 16 and 17 along with specific instructions that allow the use of muscle strength deficits to be rated in addition to other ratable factors. See, AMA *Guides*, Tables 16-31 through 16-35, pages 507-510 for upper extremities, and Tables 17-8 and 17-8 pages 531-532 for lower extremities.

If you have an upper or lower extremity case that involves muscle strength loss, make sure you read and understand the instructions in the AMA *Guides* that pertain to the use of the Tables for muscle strength deficits:

"In a rare case, if the examiner believes the individual's loss of strength represents an impairing factor that has not been considered adequately by other methods in the *Guides*, the loss of strength may be rated separately."

"...the impairment due to loss of strength *could be combined* with the other impairments, *only* if based on unrelated etiologic or pathomechanical causes." AMA *Guides*, Chapter 16, page 508.

The authors of this quote do not define the terms, “unrelated etiologic or pathomechanical causes.” Perhaps an example of this is if there was a loss of motion of the wrist, thumb or elbow joints because of an injury *and* there is muscle strength deficits due to disuse or other etiologies that are not related to the loss of motion of the joint. The instructions require the physician to state the reason why muscle strength loss is being used as a method of rating impairment either alone or in combination with other methods.

One of the most misunderstood and misquoted instructions in the *AMA Guides* involving muscle strength deficits is in the *AMA Guides*, Chapter 16, Section 16.8a, page 508:

“Decreased strength *cannot* be rated in the presence of decreased motion, painful conditions, deformities, or absence of parts (eg, thumb amputation) that prevent effective application of maximal force in the region being evaluated.”

There are many out of state physicians or reviewers who are misquoting the above instructions and making representations to claims administrators and legal counsel that muscle strength loss cannot be used as a method of determining impairment. Some medical reports written by California physicians are being second-guessed about whether muscle strength loss can be rated in workers’ compensation cases.

If you have a case where ratings based upon muscle strength loss are being described, you must develop the record and have the physician justify his or her use of this method by making sure that all of the instructions in the *AMA Guides* for the use of muscle strength loss are being properly followed.

For example, a case involves a machinist who is a long term employee of a metal shop and who has an admitted injury resulting in surgery to his right shoulder that is described in the operative report as a “partial tear, rotator cuff, debridement, decompression, and a distal clavicle resection arthroplasty.” In his MMI report, the MPN treating physician indicated that the Applicant’s permanent impairment can be rated based upon three factors – 6% upper extremity impairment due to loss of range of motion of the shoulder, 12% upper extremity impairment due to muscle strength loss and 10% upper extremity impairment due to the distal clavicle resection arthroplasty.

There are several points about this case that are worthwhile discussing for the purpose of developing the record. First of all, the physician ended up issuing three MMI reports, the original that stated the above information, and two supplemental reports which were written in response to a claims adjuster’s letters requesting clarification. The first supplemental report indicated the actual measurements the physician obtained and relied on during the permanent and stationary examination and which described how the physician arrived at the total upper extremity impairment rating of 18%. The second supplemental report indicated that the adjuster was correct in his conclusion that the total upper extremity impairment rating should not be 18% but should be 6%, based solely on the loss of range of motion of the shoulder joint.

This prompted a deposition of the treating physician which resulted in the physician reaffirming his original conclusions about the Applicant having an 18% upper extremity rating. During the deposition, the physician admitted that he was only familiar with Chapters 16 and 17 of the *AMA Guides* because he was a shoulder, elbow and knee specialist. However, he admitted that he was not familiar with the instructions in Chapters 1 and 2 of the *AMA Guides*. When asked to produce the letters from the adjuster who caused him to issue the two supplemental reports, he could not find them in his chart. It was later discovered that the letters from the adjuster were prompted by an out of state physician who, for a fee, had reviewed the original MMI report of this physician and who wrote the adjuster what to ask the physician about his use of the *AMA Guides*.

The adjuster questioned the use of muscle strength loss and the distal clavicle resection arthroplasty ratings. The adjuster stated in his letter to the treating physician that you cannot use muscle strength loss as a rating if the muscle strength deficit is caused by pain, loss of motion, deformities or loss of a part. He then stated that you can only rate distal clavicle resection arthroplasty if there is a total shoulder joint replacement. This led to the second supplemental report from the physician that concluded only the loss of motion of the shoulder joint was ratable.

In his deposition, the above quoted instructions in the *AMA Guides* were read to the physician concerning muscle strength loss and the physician testified that he had not read the instructions and now that they were pointed out to him it was his opinion that muscle strength loss is appropriate in this case because he followed the Applicant from his pre-operative status, through surgery and his post-surgical rehabilitation that lasted for six months and pain, loss of motion, deformities and loss of parts did not prevent the Applicant's effective ability to use maximum effort in the muscle strength testing. The quoted language in the instructions in the *AMA Guides* led the physician to affirm his prior conclusions about the valid use of muscle strength loss in this case since loss of motion alone was not and did not adequately reflect this Applicant's overall shoulder impairments.

As to the distal clavicle resection arthroplasty, the instructions in the *AMA Guides* were read to the physician from Chapter 16, Section 16.7b, page 505 as follows:

“Resection arthroplasty of a joint may be carried out with or without implant replacement...In the presence of *decreased motion*, motion impairments are derived separately (Section 16.4) and combined with the arthroplasty impairment.”

After reading this quote to the physician during the deposition, the physician was asked where in the instructions of the *AMA Guides* indicate that there has to be a total joint replacement in order for the 10% upper extremity rating to apply in a distal clavicle resection arthroplasty that occurred in this case. The physician testified that he was “told by other shoulder physicians” that Table 16-27 only applies in total shoulder joint replacement cases as a 10% add-on because of the wording within Table 16-27 but now that he has read the instructions in the *AMA Guides*, the patient's resection arthroplasty

rates the 10% upper extremity impairment. He agreed that the instructions in the *AMA Guides* do not require a total joint replacement to be required in order to rate for distal clavicle resections such as what occurred in this case.

Defense counsel would argue that the *AMA Guides* mandate that the physician uses the best description of the impairment applicable in a given case and this case mainly involves the loss of range of motion of the shoulder joint, the distal clavicle resection arthroplasty was due to a non-industrial osteophyte complex and the muscle strength disorder is already included in the loss of motion rating. These arguments should be developed during the deposition of the treating or evaluating physician.

This example illustrates how important it is for Judges to make sure that physicians utilize the instructions within the *AMA Guides* as much as they rely on the actual Tables and Figures to determine an impairment rating. The example also illustrates how important it is for Judges to learn the medicine as well as the law in *AMA Guides* cases.

D. Chapter 15 – Spine – DRE v. ROM

In spine injury cases, there is often an issue as to whether the DRE or ROM rating method applies in a given case.

There are inconsistent statements within the text of Chapter 15 in reference to when the ROM method applies and when the DRE method applies.

In addition, there is no definition of the term “injury” in the *AMA Guides*. The authors of the *Guides* never contemplated the California nuance that repetitive or heavy work activities can be a contributing factor to the onset of the development of an impairment – also known as a continuous trauma “injury.”

In some cases, there may be a range of evidence within the same medical report, which causes the physician to utilize both the DRE and ROM method.

The actual language in the text of the *AMA Guides* should be referred to in selecting the appropriate method. For example, in *AMA Guides* Chapter 15, page 379, the authors state that you use the ROM method:

“[If] an impairment is not caused by an injury, if the cause of the condition is uncertain and the DRE method does not apply, or an individual cannot be easily categorized in a DRE class.”

However, these terms have not yet been specifically defined.

For example, if an individual falls under a DRE Category 1, he or she has a 0% WPI. But if the physician believes the person should have an impairment rating less than 5% but greater than 0% WPI then perhaps the term “an individual cannot be easily categorized in

a DRE class” may cause one to argue the rating falls under a “DRE Gap” and the case should be rated using the ROM method.

The language in the AMA *Guides* is inconsistent and vague when it comes to when you can use the ROM method. One school of thought says that there has to be a radiculopathy in order for the ROM method to apply while the other school of thought is that there does not need to be a radiculopathy for ROM to be used. The authors of the AMA *Guides* on page 380 indicate that you use the ROM method:

“When there is multiple involvement in the same spinal region (e.g. fractures at multiple levels, disc herniations, or stenosis with radiculopathy at multiple levels or bilaterally.”

On the same page, the authors go on to say:

“Use the ROM method if:(d) there is recurrent disc herniation or stenosis with radiculopathy at the same or different level in the same spinal region...”

Does there have to be a “disc herniation with radiculopathy” or just a recurrent disc herniation for the ROM method to apply? Does there have to be radiculopathy from multiple level herniations, recurrent herniation at the same level or from stenosis or does there only have to be radiculopathy from stenosis and none required for recurrent or multi-level disc herniations?

Radiculopathy is any kind of discomfort that is coming from the spinal nerve roots – pain, numbness, shooting pain, burning, throbbing, stabbing pain or paresthesias (pins and needles sensation). The authors in the AMA *Guides* also warn us that EMG and nerve conduction studies do not detect all types of radiculopathies. So a person can complain of radicular symptoms without any positive findings on an EMG/NCV testing.

In using the DRE method, the physician must distinguish between the criteria for a DRE Category II and a Category III based at times on the difference between whether a radiculopathy is “non-verifiable” (DRE Category II) or “verifiable” (DRE Category III). The determination of whether a radiculopathy is verifiable or non-verifiable has nothing to do with the credibility of the Applicant. The determination is a medical judgment call by the physician based upon the clinical findings.

A “non-verifiable” radiculopathy is one that is based upon a positive diagnostic imaging finding, e.g. herniated lumbar or cervical disc, that produces radicular symptoms but not along a nerve distribution. For example, if a person has a left sided herniated lumbar disc at L-4 to L-5 and complains of radiating pain into the left buttock and down the left leg with normal electrodiagnostic testing (negative EMG/NCV) this would be a non-verifiable radiculopathy. However, if the person was having the top of his or her left foot with paresthesias (sensation of pins and needles) with a left sided herniated lumbar disc at L-4 to L-5, and negative EMG/NCV would be a verifiable radiculopathy because of the parasthesia is occurring along the peroneal nerve distribution which is a branch of the

tibial nerve coming from the sciatic nerve. See *AMA Guides*, Chapter 17, Figure 17-8, page 551).

Example #1:

BARTENDER/WAITRESS LIFTING TRAY OF FOOD FEELS “CRACK” IN LUMBAR, THORACIC SPINE AND RIGHT HIP.

MRI SHOWS 2-3mm DISC BULGES AT L3-L4, L4-L5 AND L5-S1 WITH ANNULAR TEARS AT L5 AND S1

QME SAYS DRE CATEGORY 2, 5% WPI BECAUSE IMPAIRMENT WAS CAUSED BY AN “INJURY.”

QME ALSO SAYS ROM IS 9% WPI LUMBAR, 0% WPI AT THORACIC, 0% WPI RIGHT HIP BECAUSE LEFT HIP HAS SAME DECREASED ROM.
DRE OR ROM APPLIES – 5% OR 9% WPI?

USE THE ROM METHOD IF “AN IMPAIRMENT IS NOT CAUSED BY AN INJURY, IF THE CAUSE OF THE CONDITION IS UNCERTAIN AND THE DRE METHOD DOES NOT APPLY, OR AN INDIVIDUAL CANNOT BE EASILY CATEGORIZED IN A DRE CLASS.” *AMA GUIDES*, PAGE 379.

DRE APPLIES BECAUSE APPLICANT HAD A SPECIFIC INJURY vs. ROM APPLIES BECAUSE APPLICANT HAS MULTIPLE LEVEL PATHOLOGY WITHIN THE LUMBAR SUB-REGION or APPLICANT CANNOT BE EASILY CATEGORIZED USING DRE.

- *AMA GUIDES* DO NOT DEFINE THE TERM “INJURY”
- *AMA GUIDES* DO NOT ANTICIPATE THE EXISTENCE OF A CONTINUOUS TRAUMA “INJURY”
- *AMA GUIDES* DO NOT DEFINE THE TERM “SOFT TISSUE LESION” IN TABLE 15-7, PAGE 404.

STRICT INTERPRETATION OR LIBERAL INTERPRETATION?

kkkk

The Spinal Impairment Evaluation Process flow chart, *AMA Figure 15-7* at 380, Differentiates between the two based on whether there was an injury or an illness. But, the written instructions which precede it are more detailed and complicated. The AME, if following the flow chart, could point to that as a basis for use of the DRE method.

A converse situation occurs if an applicant had an injury, underwent surgery, and the physician found “0” WPI. What if the AMA Guides gives a diagnosis based WPI, even if the surgery is successful, with no subsequent complaints. DRE Category III for the lumbar spine assigns 10-13% range for a person who has had surgery and is asymptomatic. AMA Table 15-3 at 384. Or, for a shoulder, a distal resection arthroplasty takes a WPI of 6. AMA Table 16-27 at 506. What occurs if the physician determines 0 WPI, as the surgery was successful and applicant is asymptomatic?

The AMA Guides urge a physician to use his clinical judgment in assessing impairment. But The Guides use different methods of assessing impairment for different conditions. Is the physician, rater or Judge compelled to find a diagnosis based impairment if the physician concludes there is no functional problem after the surgery or treatment? An applicant’s attorney would argue that the use of the diagnosis based impairments for particular body parts and conditions requires that the charted impairment should be assigned. We would also expect an applicant’s attorney to argue that physical descriptions and impairment assignments in the Guides must be observed under Labor Code §4660(b)(1). A defendant would argue that the Guides are part of the PD determination, are *prima facie* evidence under Labor Code §4660(c) and the physician could assign a different impairments. The arguments cut both ways, given the particular situation.

E. Chapter 15 - Spine – Failed Lumbar Syndrome

A separate discussion of failed lumbar syndrome is in order for counsel to understand the medical-legal issues that occur in these cases. One question arose where an AME orthopedic surgeon asked how can a case be rated where the physician felt that AMA *Guides* Chapter 15, The Spine, did not adequately reflect what the physician thought should apply where the patient had a failed lumbar syndrome with the use of a cane.

First, you need to understand what a “failed lumbar syndrome” consists of. The purpose of any spinal surgery is to reduce pain, eliminate radiculopathy and to improve personal, social and occupational functioning. In many cases, there are multiple pathologies that occur within the lumbar spine at the same time. For example, a patient could have any combination of a herniated intervertebral disc with nerve root impingement, spondylosis, spondylolysis, spinal canal stenosis, neural foramina stenosis or spondylolithesis. In fact, any kind of intervertebral movement (antero or retrolisthesis) is a sign of what is referred to as “mechanical back pain.” Patients with mechanical back pain suffer severe pain with movement such as extension, flexion or lateral flexion of the lumbar spine.

In certain cases, major spinal surgery is undertaken where the patient’s outcome would have been better had there been no surgery in the first place. The problem is that no one can predict with reasonable medical probability who will benefit from spinal surgery and who will not. If a patient has spinal surgery and after recovering from the initial effects of surgery do not improve with pain reduction and increased functioning then the patient is considered to have failed lumbar syndrome. So if no other new pathology is

discovered post surgically such as a disc fragment or recurrent disc herniation, then the diagnosis of failed lumbar syndrome may be appropriate. Note that the patient does not need to have multiple pathologies for this to occur – we have seen failed lumbar syndrome occur in cases with only a one level herniated lumbar disc after surgical correction. Some failed lumbar syndrome patients do not get relief from their pain except until after either an implanted spinal stimulator or morphine pump is installed. There are as many cases of failed lumbar syndrome cases outside the workers' compensation system as there are within the system.

This being said, failed lumbar syndrome is very rare and the vast majority of patients nationally who have back surgery recover with very little residual personal, social or occupational functioning deficits. But we have seen the bad cases enough to question how can these cases be rated under the *AMA Guides*?

For the example above – where the patient has failed lumbar syndrome with use of a cane, there are several potential ways to rate a case like this. If the reason for the use of the cane is because of neuropathic pain, then the following methods can be used:

1. DRE or ROM rating as appropriate; or
2. DRE or ROM rating combined with:
 - Chapter 17, Section 17.21 rate sensory and motor = Grade 0-5 x maximum sensory or motor value of effected nerve distribution (combine sensory and motor impairments); or
 - Chapter 13, Section 13.5, page 336, Table 13-15 station and gait impairment due to peripheral nerve impairment; or
 - Chapter 17, Table 17-5, page 529, lower limb impairment due to gait derangement; or
 - Chapter 13, Section 13.9 criteria, Tables 13-23 and 13-24 pages 344-351 and the “method” Section 1 on page 350. This is used for neuropathic pain/sensory deficit and motor function impairments such as that caused by “drop foot.”

When the use of a cane is included then you use the highest rating for the lower extremity impairment and combine it with the spinal impairment rating.

In some failed lumbar spine cases, the physician may try to justify the use of other chapters in the *AMA Guides* such as the sections in Chapters 13 and 17 listed above and combine them with the spinal impairment rating from Chapter 15. In fact, Table 13-15 mentioned above under Chronic Pain Syndromes can be used in cases of neuropathic pain in combination with a failed lumbar syndrome. Case law may have to be developed on the question of whether in failed lumbar syndrome cases a physician can utilize the DRE

or ROM method of rating within Chapter 15 and then combine that rating with one from either Chapter 13 or 17.

In the above example, the physician rated the failed lumbar spine impairment using the DRE method and came up with a 28% WPI rating and then combined it with a 15% WPI for the use of assistive devices under Table 17-5. The physician stated in his AME report how and why he came to the conclusion that the DRE or ROM methods in Chapter 15 were not adequate in his opinion to describe this patient's impairment due to the severe failed lumbar syndrome – the patient absolutely had to depend upon the use of a cane in order to ambulate safely because of muscle spasms from his back along with continuing radiculopathy and weakness in his leg.

In a rare case, a patient with failed lumbar syndrome also has bladder control problems, especially in a cauda equina syndrome case (See *AMA Guides*, page 383 and Example 15-18, page 398 for a description of cauda equina syndrome). In such a case, a rating under Chapter 15 DRE or ROM may be combined with the DRE rating under the Corticospinal Tract section (See *AMA Guides*, Chapter 15, pages 395-398). Table 15-6, pages 396-397 is the same table as *AMA Guides*, Chapter 13, Table 13-19, page 341 for bladder control due to a “neurogenic” lumbar spinal impairment.

Can an orthopedic surgeon rate a bladder control problem along with the actual spinal impairment rating? The *AMA Guides* allow for any duly licensed medical doctor to rate any impairment as long as the instructions, descriptions and measurements of the *AMA Guides* are followed and the underlying diagnosis is valid and reproducible (See Chapter 1 of the *AMA Guides*). The orthopedic surgeon should send the applicant to a urologist to perform urodynamic testing to confirm a neurogenic problem as opposed to a localized problem with the bladder, ureter or kidneys. So the failed lumbar syndrome with use of a cane and bladder control problems can have three separate ratings combined.

If the applicant does not have neuropathic pain causing the use of a cane and the patient uses one because of “instability” due to pain, then the *AMA Guides* state on page 529, with Table 17-5 that you cannot use lower limb impairment due to gait derangement if based only on subjective complaints of low back discomfort. There has to be a neuropathic cause to justify the use of a cane.

III. Evidentiary Considerations & Developing the Record

Braewood Convalescent Hospital v WCAB(Bolton) (1983) 34 C3d 159, 48 CCC 566

WCAB's Preferred Method of Developing the Record: *McDuffie v. LA Cty Met. Auth.* (2002) 67 CCC 138 (WCAB en banc). “The case concludes that where the medical record requires further development either after trial or submission of the case for decision, the preferred procedure is first to seek supplemental opinions from the physicians who have already reported in the case. If the supplemental reports or depositions of the previously reporting physicians cannot or do not sufficiently develop the record, an agreed medical evaluator (AME) may be considered. Finally, if none of

these options succeeds or is possible, the WCJ or the Board may then appoint a medical examiner.”

See also: *Tyler v WCAB* (1997) 56 CA4th 389, 62 CCC 924; *McClune v WCAB* (1998) 62 CA 4th 1117, 63 CCC 261; *M/A Com-Phi v WCAB* (1998) 65 CA 4th, 63 CCC 821; *San Bernardino Community Hospital v WCAB (McKernan)* (1999) 74 CA4th 928, 64 CCC 986

Recent case law: *Shank v. WCAB*, (2006) 71 CCC 1735 (5th DCA - **unpublished decision**) DCA upheld WCJ’s order to exclude A’s QME report obtained after MSC, per LC 5502(e)(3), *Zuniga* (2001) 66 CCC 1290 and *McKernan* (1999) 64 CCC 986. DCA stated, that A should have presented evidence at trial to establish their due diligence in obtaining appropriate medical evidence in a timely manner.

Savemart v. WCAB (Oneto), (2006) 71 CCC 1727 (5th DCA - **unpublished decision**) DCA upheld WCJ’s order (and WCAB’s D&I) to exclude defense sub rosa videos taken AFTER beginning of trial in violation of LC §5502(e)(3). DCA rejected defense argument that inclusion of videos as evidence was consistent with WCAB’s duty to develop the record per LC §5701, and stated in fn. 2 that videos were not listed in LC §5701. But see LC §5703(c) and the rubric “...and other records properly authenticated.”

IV. Comparing Apples with Oranges APPORTIONMENT, DUPLICATION AND OVERLAP

This subject has been and will continue to be a highly litigated and controversial issue, even in *AMA Guides* cases. The *AMA Guides* in fact make our cases ripe for litigation and controversy on the issue of apportionment. Apportionment in the *Guides* looks somewhat like Labor Code Section 4663. See *AMA Guides*, Chapter 1, pages 11-12. However, it appears that the authors of Chapter 1 of the *Guides* confuse causation of an injury with causation of an impairment. California law requires that we distinguish between causation of an injury [See *Reyes vs. Hart Plastering*, (2005) 70 Cal. Comp. Cases 223], and causation of permanent disability at the time the Applicant is permanent and stationary or has reached maximum medical improvement. See *Marlene Escobedo vs. Marshalls*, (2005) 70 Cal. Comp. Cases 604; *E.L. Yeager Construction vs. WCAB (Gatten)* (2007) 72 Cal. Comp. Cases 1687.

The important point here is that even the authors of the *AMA Guides* mandate the individualization of each person’s impairment rating. Labor Code Section 4660 mandates that the state utilize a uniform, objective and consistent method of rating industrial injuries. What is clear from reading Chapters 1 and 2 of the *AMA Guides* is that the only thing that is “uniform, objective and consistent” as mandated by the Labor Code is the actual use of the *AMA Guides*. But once you open the *Guides* and use its pages in a given case for a given applicant, any uniformity, objectivity or consistency are

discarded in favor of both individualizing a person's impairment rating based in part on the effects of the impairment on that person's ADLs and individualizing apportionment of impairments to "other factors" if appropriate.

How do we deal with a prior award under Labor Code Sections 4663 and 4664 when there is a new injury that occurs after January 1, 2005 and is rated under the *AMA Guides*? Suppose there is a 39 year old nurse who sustains a low back injury in 1995 that resulted in a no heavy work restriction. That case would rate 30% permanent disability after adjustment for age and occupation. Now, in 2005, the same nurse has another lumbar spine injury. How would apportionment work in this case?

Can you subtract apples from oranges? The 1995 permanent disability was based upon work restrictions. The 2005 permanent disability is based upon a spinal impairment under Chapter 15, The Spine, in the *AMA Guides*. So the 1997 PDRS is based upon loss of ability to compete in the open labor market while the 2005 PDRS is based upon the *AMA Guides* and the DFEC adjustment. Cases under the 1997 PDRS are the apples and cases rated under the 2005 PDRS are the oranges

One preliminary note: since there is a reoccurrence of an injury to the nurse's lumbar spine, the ROM method would apply for rating the 2005 spinal injury. See Section 3.15 of this guidebook. One other note is that the following analysis applies regardless of whether the prior injury was industrially related or not – the analysis applies under both Labor Code Section 4664 for a prior award and Section 4663 for a prior non-industrial injury with the same surgical results.

Can the WCJ subtract the prior percentage of permanent disability from the current permanent disability that was rated from permanent impairment to PD using the 2005 PDRS? No. There is no way you can use the direct subtraction of percentages now mandated by Labor Code Section 4664 and current case law. [See *Welcher/Brodie vs. WCAB* (2007) 40 Cal.4th 1313, 72 Cal. Comp. Cases 565]. This is because the percentages of permanent disability derived from impairment ratings are totally different from the ratings based upon work restrictions. Another way to put it is that you would be subtracting apples from oranges, which you cannot do. Therefore, there would be only two ways apportionment can occur in this type of case, both under Labor Code Section 4663:

- I. Have the treating or evaluating physician determine what impairment rating under the *AMA Guides* the prior injury would have been and subtract that impairment rating from the current one.

OR

- II. Default to analyzing apportionment under Labor Code Section 4663 – what approximate percentage of permanent disability is directly caused by the 2005 lumbar spine injury and approximately what percentage of permanent

disability is caused by other factors, including the prior 1995 industrial lumbar spine injury?

Chapter 1 of the *AMA Guides* permit the first method mentioned above if the physician can rate the prior injury using the *AMA Guides* retrospectively. For example, if the nurse had suffered a one level lumbar disc herniation resulting in a laminectomy from the 1995 injury then a physician today using the *AMA Guides* could reasonably conclude that the nurse had a DRE Category III lumbar spine impairment rating (between 10% and 13% WPI) if the physician can discover through review of records, reviewing the Applicant's deposition etc. that the nurse had surgery and determine his or her quality of life afterwards.

The physician could then pinpoint approximately where within the DRE III category the nurse was when declared permanent and stationary from the 1995 injury based upon how well the nurse felt or functioned after being released from care for the first injury. Since the ROM method would be used due to the new injury to the lumbar spine in 2005, the physician would then subtract the DRE III rating from the current ROM rating, which would be consistent with both Labor Code Section 4664 and 4663.

Applicant's counsel may object to the first method on the grounds that a retroactive DRE rating under the *AMA Guides* is too speculative. Defense counsel may object since this method does not take into account "other factors" besides the prior ratable injury. However, it is reasonable from an evidentiary standpoint that this method could pass scrutiny by the WCAB as to whether the physician's opinion that gives a retroactive impairment rating constitutes substantial medical evidence. Again, the physician would have to state how and why he or she came to his or her conclusions about a retroactive impairment rating and the rationale for doing so.

We are also faced with the issue under Labor Code Section 4663 about whether the nurse could argue that her lumbar spine condition improved and she rehabilitated from the prior injury since the presumption of Labor Code Section 4664 cannot apply (remember, you cannot subtract apples from oranges). See *Kopping vs. WCAB* (2006) 71 Cal. Comp. Cases 1229.

But what if the nurse injures her neck instead of her lumbar spine in 2005? How does apportionment work where the prior spinal award or injury was to the lumbar spine and the new industrial injury is to the cervical spine? Is there consideration for overlap? Is there such a thing as overlap and duplication in *AMA Guides* cases?

If the nurse has a prior lumbar spine award of 30% permanent disability based upon the 1995 injury and now she has a DRE Category IV 25% cervical spine impairment, is there any adjustment to the cervical spine rating on account of the prior award to the lumbar spine? Maybe not, even though the impairments are within the same region, i.e. the spine. Remember, Labor Code Sections 4664(c)(1) and (c)(2) mandate that an impairment rating cannot exceed 100% in a person's life time for any

single body region, including the spine. In this case, it is arguable that a cervical spine injury results in separate impairments than a lumbar spine injury.

If the nurse had both cervical and lumbar spine injury in 2005, each impairment rating would be combined using the Combined Values Chart and then rated for permanent disability with any “overlap” being covered by the Combined Values Chart. See the 2005 PDRS, page 1-11.

However, the 2005 PDRS at page 1-5 states:

“It is not always appropriate to combine all impairment standards resulting from a single injury, since two or more impairments may have a duplicative effect on the function of the injured body part. The *AMA Guides* provide some direction on what impairments can be used in combination. Lacking such guidance, it is necessary for the evaluating physician to exercise his or her judgment in avoiding duplication.”

One example would involve a single injury to the elbow and shoulder of the same arm resulting in muscle strength deficits – reduced strength of the elbow would probably overlap with reduced muscle strength in the shoulder. Notice here, that the 2005 PDRS refers to multiple impairments resulting from a single injury to the same region. It is doubtful that this rule in the 2005 PDRS would apply to impairments to different regions of the body from the same injury.

Therefore, it is an open question about whether duplication and overlap occur in *AMA Guides* cases. Defendants may want to make the medical-legal argument that there is overlap and duplication for impairments that occur within the same region like in spinal injury cases involving impairments to the cervical and lumbar spine caused by the same injury. Applicant’s counsel may argue that Labor Code Section 4664(c)(1) and (c)(2) already account for overlap and duplication as does the application of the Combined Values Chart.

However, in the example above involving the nurse, since the lumbar spinal injury and the cervical spinal injury occurred separately, ten years apart, there probably is no overlap or duplication unless it can be proven that the effects on the Applicant’s ADL functioning for each injury overlap in some manner. One can argue that ADL functioning is affected differently for a lumbar impairment than they are affected by a cervical spinal impairment.

1.10.08